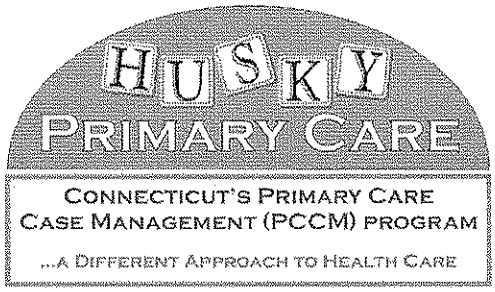

A Report on the Progress of Connecticut's Primary Care Case Management Pilot Program

HUSKY Primary Care

- What is PCCM?
- Implementation, Year One
  - Provider recruitment
  - Client information/education
  - Roll out of pilot sites
  - Development of protocols and quality improvement – Provider Advisory Group
  - Data analysis/evaluation
- Plans for the Future
- Lessons Learned

Legislative Mandate for PCCM

- Section 16, Public Act No. 07-2, June Special Session:
  - the Commissioner of Social Services will initiate "a primary care case management pilot program of not less than one thousand individuals who are otherwise eligible to receive HUSKY Plan, Part A (Medicaid managed care) benefits."

PCCM requirements under 1915(b) waiver (for Medicaid managed care)

- Pursuant the terms of the amendment to its 1915 (b) Medicaid Managed Care Waiver (HUSKY A), the Department of Social Services was further directed to implement the following changes to the Primary Care Case Management (PCCM) Pilot Program:
  - PCCM shall be operational in the Greater New Haven and Greater Hartford areas no later than January 1, 2010.
  - The Commissioner of Social Services shall commission an independent evaluation of the cost, quality, and access impacts of the PCCM programs in Waterbury and Windham by July 1, 2010 and shall submit the evaluation to the Human Services and Appropriations Committees. The Commissioner shall identify any deficiencies in the program and recommend remediation measures.
  - PCCM shall be operational in additional geographic areas that the Commissioner approves after July 15, 2010 provided: (A) the independent evaluation finds that the PCCM program is successful in containing costs and improving quality and access; and (B) an adequate number of primary care physicians (PCP's) for both children and adults have submitted applications with the Department of Social Services.
  - New PCPs shall be allowed to enroll in PCCM at any time in any geographical area where PCCM is in effect.
  - The Department of Social Services shall inform HUSKY A enrollees in approved geographic areas of the availability of PCCM to the same extent that the Department informs such enrollees of the ability to enroll in a Managed Care Organization.
  - For purposes of this amendment, "geographical area" means Hartford, New Haven, Waterbury, and Windham, and towns that are contiguous to said cities.
  - The Department of Social Services will report to the Human Services and Appropriations Committees on the status of the PCCM program on January 1, 2010.

What is PCCM?

- **Primary care case management** means a system under which a PCCM contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid recipients.
- **Primary care case manager (PCCM)** means a physician, a physician group practice, an entity that employs or arranges with physicians to furnish primary care case management services or, at State option, any of the following:
  - (1) A physician assistant.
  - (2) A nurse practitioner.
  - (3) A certified nurse-midwife.

What is PCCM?

- PCCM is managed care without the managed care organization
- Clients enroll with a provider, rather than an MCO
- The provider receives a $7.50/member/month payment (in addition to fees for clinical services) to provide care coordination
- It is not a Patient-Centered Medical Home model, but is striving to get there

Implementation, Year One

- **Provider recruitment**
- Client information/education
- Roll out of pilot sites
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- Data analysis/evaluation

Provider Recruitment

- "Wide net" recruitment effort
  - Professional groups and associations
  - Trade groups
- Targeted provider outreach
  - AAP "Lunch and Learn"
  - Academic and hospital department presentations
  - Regional medical societies
- Formal provider forums
  - New Haven and Hartford (October, 2008)

Provider Recruitment

- Eligible providers
  - Primary care providers
    - Physicians – pediatricians, internists, family physicians, obstetricians, and in some cases, specialists
    - Nurse Practitioners
    - Certified Nurse Midwives
    - Physician Assistants under the direction of a physician
- Need to care for family 'assistance units' – must have providers for both children and adults

Provider Recruitment

- Regional pilot sites (to be described)
  - Waterbury – 41 providers from 2 private pediatric practices, StayWell Health Center and the Franklin Medical Group
  - Windham – 13 providers from 2 private pediatric practices and the Generations Family Health Center
  - Hartford – 49 providers from the Burgdorf/Bank of America Health Center, East Hartford Community HealthCare, Community Health Services, Inc., the Charter Oak Health Center (excluding their CCMC site), and the Family Medicine Center at Asylum Hill
  - New Haven – 125 providers from the Cornell Scott-Hill Health Center, Fair Haven Community Health Center, the Primary Care Centers at Yale/New Haven Hospital, and 4 private pediatric practices

Implementation, Year One

- Provider recruitment
- **Client information/education**
- Roll out of pilot sites
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Client information/education

- Member notices –
  - Direct marketing with over 52,000 notices to clients announcing the available 4th option
  - Ongoing inclusion in mailings to newly eligible HUSKY A clients as a 4th HUSKY health care option
- HUSKY Primary Care brochure and signs – provided to providers for their office, as well as DSS offices
- Comparison chart - "Tips on Choosing a HUSKY A Option"
- Department websites (www.huskyhealth.com)

Implementation, Year One

- Provider recruitment
- Client information/education
- **Roll out of pilot sites**
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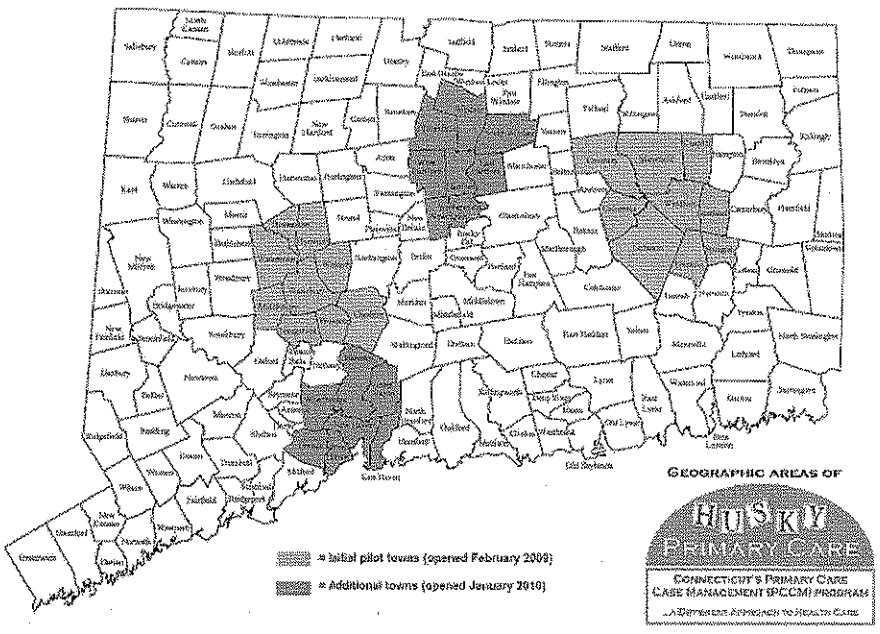
Roll Out of Pilot Sites

- PCCM was rolled out in stages
  - Existing patients of participating Waterbury and Windham practices – February 1, 2009
  - All eligible clients living in Waterbury, Windham and their contiguous towns – July 1, 2009
  - Hartford, New Haven and contiguous towns – January 1, 2010
- Why gradual?
  - Provider fears of deluge of new Medicaid patients
  - Allow providers to get comfortable with new case management responsibilities
  - Following legislative amendment to 1915(b) waiver

Roll Out of Pilot Sites

- Outreach to providers
- Provider applications, contracting, and review; enrollment in Title 19/Medicaid, if needed
- Speaking and meeting with interested providers, working with them on new requirements and program-specific items (for example, accessing monthly client roster)
- Systems setup
  - Each PCP is set up in both our MMIS and in our client enrollment system as if they are a new "health plan"
- Creating and sending new notices and brochures to all HUSKY clients
- Additional information and/or training to DSS staff, other entities (ACS, HUSKY InfoLine, community organizations, etc.)



Overall HUSKY A population in HUSKY Primary Care pilot areas

	HUSKY A population	% total statewide HUSKY A enrollment
Original Pilot Areas (as of 2/1/09):		
Windham/Willimantic Area	8,075	**2.3%**
Waterbury Area	36,444	**10.3%**
New Areas (as of 1/1/10):		
New Haven Area	44,244	**12.5%**
Hartford Area	57,331	**16.2%**
Total across all four areas	**146,094**	**41.2%**

* Based on October 2009 enrollment

Implementation, Year One

- Provider recruitment
- Client information/education
- Roll out of pilot sites
- **Development of protocols and quality improvement – Provider Advisory Group**
- Data analysis/evaluation

Provider Advisory Group

- Key component of successful models in other states
- Volunteer providers from practices around the state interested in participating – do not have to be from participating sites
- Developed practice guidelines, disease measures, methods and mechanisms of data reporting

Provider Advisory Group - subcommittees

- Care Coordination – Sandra Carbonari, Chair
  - Developed recommendations for patient risk assessments, structured care plans
  - Training for practices on both risk assessment and care plans
- Disease Management – Nancy Quimby, APRN, Chair
  - Disease management protocols for children's asthma, adult onset diabetes, obesity in all age groups
  - Recommended disease-specific outcomes measures
- Data Collection/Evaluation – Marjorie Berry, Chair
  - Recommended data to be reported, data reporting formats and reporting tool
  - Recommendations on claims-based reporting measures

Implementation, Year One

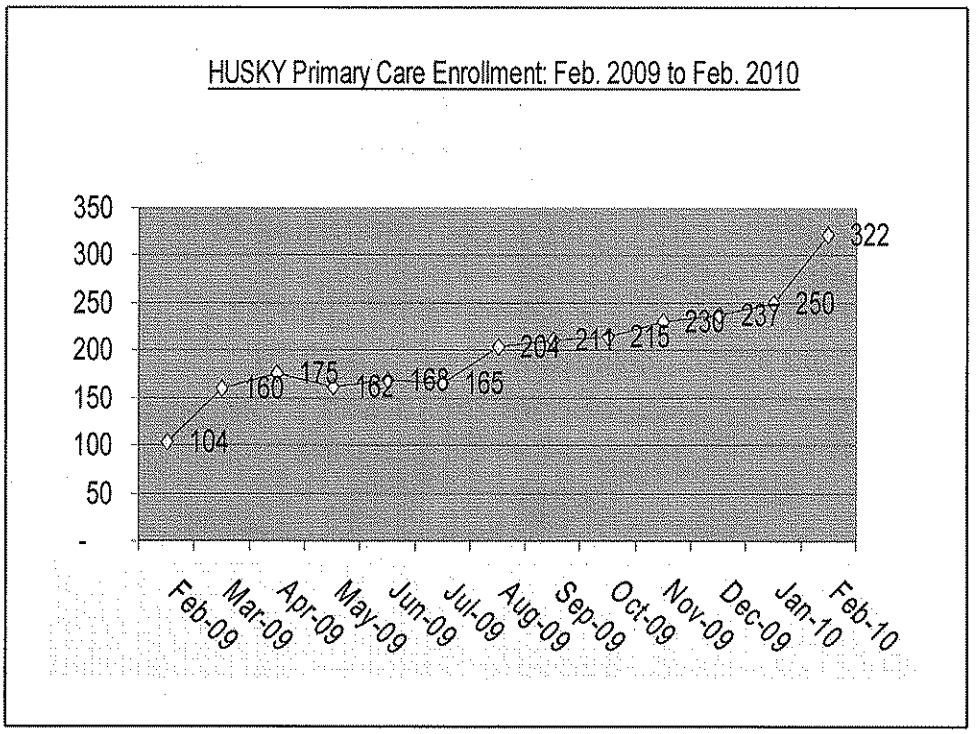
- Provider recruitment
- Client information/education
- Roll out of pilot sites
- Development of protocols and quality improvement – Provider Advisory Group
- **Data analysis/evaluation**

Data analysis/evaluation

- Provider reported measures, based on Provider Advisory Group:
  - Completion of a risk assessment and care plan
  - Asthma among children: completion of severity staging and care plans
  - Diabetes among adults: Annual HbA1c and lipid levels; biannual blood pressure
  - Obesity: BMI, and for those with a BMI above a specific level, other clinical measures

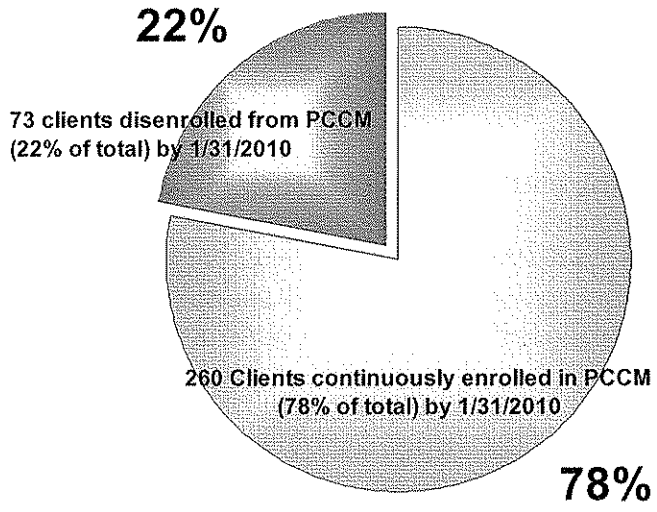
Data analysis/evaluation

- Shorter-term, including:
  - Immunization, inpatient and emergency department utilization (generally, and related to asthma or diabetes), preventive and well-care, asthma medications, developmental screening, EPSDT screening and participation ratios, outpatient drug utilization
- Longer-term, including:
  - Breast and cervical cancer screening, antibiotics for upper respiratory infections among children, antibiotics for bronchitis among adults



Husky Primary Care: Enrollment & Disenrollment

333 Total Unduplicated Enrollees in HPC as of 1/31/2010



HUSKY Primary Care: Disenrollment & Destination

Length of Enrollment in PCCM	Total Disenrollment = 73	Destination	
		MCO	Lost Eligibility
1 - 2 months	33 [45% of Total 73]	31	2
3 months and more	40 [55% of Total 73]	18	22

- 9 clients subsequently re-enrolled in to PCCM after losing eligibility and being re-instated into HUSKY

Plans for the Future

- Independent evaluation – Mercer Government Human Services Consultants (HUSKY Program's external quality review organization)
  - To be submitted to the General Assembly in July
  - Specific proposal/specifications currently being reviewed
- Continued growth of client enrollment (budget assumes 1,150 by June, 2010 and 3,000 by June, 2011)
- Continuation of data collection and analysis – claims-based and provider reporting
- Possible further expansion state-wide depending upon results of evaluation

Lessons Learned

- HUSKY Primary Care is a pilot
- Generally, other states with successful PCCM programs (such as North Carolina and Oklahoma):
  - Set them up over several years
  - Surround them with significant infrastructure and resources in addition to the case management fee
  - Pay providers FFS rates which equal or approach Medicare fees

Lessons Learned – from PCPs

- PCCM is a new concept that is hard to explain to providers (and much harder to explain to consumers)
- Pediatricians are generally committed to Medicaid, HUSKY, and care coordination; internist and family physician buy-in is more challenging
- Access to PCPs for adults is a problem (not just in Medicaid)
- Many practices do not offer after hours and weekend access to care
- Few PCP offices have successfully implemented Electronic Medical Records
- Many providers do not have the staff, expertise, and time to collect data

Lessons Learned - from specialists

- Access to some specialty care under Title XIX is limited in some areas
- Physicians feel enrollment in Title XIX is cumbersome and may be a barrier to access to care
- Many specialists provide services which they feel PCPs should provide
- Many obstetricians do not wish to take on many of the responsibilities of PCPs
- Coordination of care between specialists and PCPs needs improvement

Lessons Learned – from clients

- Many like, or at least are comfortable with, the HUSKY MCOs
- Trusting their PCP to take the place of an MCO requires a leap of faith, especially with a new program
- Specialty care, especially outside of major teaching hospitals, is a concern
- Many who ask their PCP if the care they receive under HUSKY Primary Care will be different from what they get with them under an MCO are told "no"

Lessons Learned – from DSS

- Our systems are well-designed for managed care and less-so for a different model
- System changes to support PCCM will require already scant resources to be taken from other priorities
- While necessary, meeting with providers' offices and staff is time-consuming, inefficient
- Collecting data, enrolling providers, and otherwise managing a 4th coverage option requires considerable DSS staff resources and is very time consuming

Lessons Learned – Main Barriers to Broader Expansion

- Access to PCPs for both adults and children
- Access to Title XIX specialists
- Systems, resources, administrative services capabilities
- Still a learning experience; effects on patient care and costs in Connecticut still unclear

Lessons Learned

We have a community of care givers, advocates, legislators, contracted vendors, DSS staff members, and others who care deeply about the services provided to our clients.